A4

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NON-DHS/NON-COUNTY WORKFORCE MEMBER HEALTH CLEARANCE INSTRUCTIONS

Welcome to Los Angeles County, Department of Health Services. You are required to obtain a health clearance by Employee Health Services (EHS) prior to beginning your work assignment. You must successfully complete the Human Resources in-processing and criminal background check prior to beginning the EHS health clearance process. This packet includes health screening forms and questionnaires that should be completed prior to your visit to EHS for your health clearance. The completed forms should be presented to EHS on the day of your appointment/visit. Please bring the following forms with you to EHS at your office visit/appointment:

- ☐ **B-NC** **Tuberculosis History and Evidence of Immunity** (please complete page 1)
- ☐ **K-NC** **Declination** (as applicable)
- ☐ **P-NC** **Respirator Medical Questionnaire** (only if respirator is needed for job assignment, please complete pages 1 and 2)
- ☐ **T1-NC** **General Consent**
- ☐ **T4-NC** **Notice of Privacy Practices**

By providing these documents, you can help expedite the processing for an EHS health clearance:

1. **Tuberculosis (TB) Test Record** *(a copy of any **one** of the following)*:

   Completed within the last 12 months

   - ☐ 2 negative Tuberculin Skin Test (TST) records documented in millimeters (This is a two-step TST)
   - ☐ 1 negative TST record documented in millimeters
   - ☐ 1 negative single blood assay for M. tuberculosis (BAMT)

   For a positive TB result, submit a Chest X-Ray Report within the last 12 months

   - ☐ 1 positive TST record documented in millimeters with a Chest X-Ray Report
   - ☐ 1 positive BAMT record with a Chest X-Ray Report

2. **Immunizations Record** and/or Titers to the following:

☐ Measles	☐ Varicella	☐ Acellular Pertussis
☐ Mumps	☐ Tetanus	☐ Influenza
☐ Rubella	☐ Diptheria	☐ Hepatitis B

The following will be obtained at EHS:

- o A two-step TST will be conducted if you cannot provide documentation of 2 negative TST records within the previous 12 months. This may require a total of 3 office visits.
- o A TST will be conducted if you can only provide documentation of 1 negative TST record within the previous 12 months. This may require a total of 2 office visits.
- o If you have been documented with a positive TST or positive BAMT result, you will be required to have a baseline chest x-ray prior to work assignment **OR** provide written documentation of a normal chest x-ray taken no more than 12 months prior to work assignment.

- EHS will assess the immunization documents you provide to determine if you meet evidence of immunity to vaccine-preventable diseases as a requirement for the assignment.

☐ **YOUR APPOINTMENT IS SCHEDULED ON _____ AT _____ AM / PM.**

☐ **APPOINTMENT NEEDED, PLEASE CALL _____.**

☐ **NO APPOINTMENT NEEDED, PLEASE WALK IN DURING THE FOLLOWING OFFICE HOURS:**

DAY	TIME	LOCATION
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

If you have any questions or need assistance, please contact the facility EHS office.

Thank you,

DHS EMPLOYEE HEALTH SERVICES

B-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL

NON-DHS/NON-COUNTY WORKFORCE MEMBER TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

See General Instructions on Last Page

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

HOME ADDRESS:	CITY	STATE:	ZIP CODE:

E-MAIL ADDRESS:	HOME PHONE NO.:	CELL PHONE NO.:

JOB CLASSIFICATION:	DHS FACILITY:	DEPT/DIVISION:	WORK AREA/UNIT:	SHIFT:

NAME OF SCHOOL/EMPLOYER *(If applicable)*:	PHONE NO.:	CONTACT PERSON:

FOR COMPLETION BY WORKFORCE MEMBER (WFM)

TUBERCULOSIS QUESTIONNAIRE

YES	NOT SURE	NO	
			TUBERCULOSIS (TB) HISTORY
☐	☐	☐	1. Do you have history of a negative TB skin test?
☐	☐	☐	2. Do you have documentation of your negative test from the last 12 months?
☐	☐	☐	3. Do you have a history of a positive TB skin test?
☐	☐	☐	4. Do you have documentation of your positive skin test in millimeters?
☐	☐	☐	5. Do you have documentation of a chest X-ray within the last year?
☐	☐	☐	6. Have you received treatment for TB (INH)?
☐	☐	☐	If "yes", how many months? _____
☐	☐	☐	7. Do you have treatment documentation?
☐	☐	☐	8. Have you ever been diagnosed as having active or infectious TB?
☐	☐	☐	9. Have you received a TB vaccine called BCG?
☐	☐	☐	10. Have you had a weakened immune system due to (check all that applies):
			☐ Chemotherapy ☐ HIV ☐ Organ transplant ☐ Leukemia ☐ Cancer or medications ☐ Hodgkin's Disease ☐ Steroids (e.g., prednisone)
			Note: Having immunodeficiency increases a person's risk for active TB infection/disease. If you think you may be immunocompromised you should consult with your physician or licensed health care professional. DHS-EHS does not test for HIV or related diseases.
			TUBERCULOSIS (TB) SCREENING
☐	☐	☐	11. Do you have a cough lasting longer than three (3) weeks?
☐	☐	☐	12. Do you cough up blood?
☐	☐	☐	13. Do you have unexplained or unintended weight loss?
☐	☐	☐	14. Do you have night sweats (not related to menopause)?
☐	☐	☐	15. Do you have a fever or chills?
☐	☐	☐	16. Do you have excessive sputum?
☐	☐	☐	17. Do you have excessive fatigue?
☐	☐	☐	18. Have you had recent close contact with a person with TB?

NON-DHS/NON-COUNTY WORKFORCE MEMBER SIGNATURE	DATE

LAST NAME	FIRST NAME	BIRTHDATE	IDENTIFICATION NO.

FOR COMPLETION BY EMPLOYEE HEALTH STAFF – OR – DESIGNATED WFM AGENCY

TUBERCULOSIS DOCUMENTATION HISTORY

A

TUBERCULIN SKIN TEST RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal

DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS Indicate: Reactor Non-Reactor Converter
	1st									
	2nd									

If either result is positive, send for CXR and complete Section C below.

OR

B	Negative BAMT (<12 months)	Date:	Results	☐ LA County ☐ Outside Document	**STATUS**

If CXR is positive for TB, DO NOT CLEAR for hire/assignment.
Refer Workforce Member for immediate medical care.

C	Positive TST	Date:	Results _____mm	☐ LA County ☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ LA County ☐ Outside Document	

OR

D	Positive BAMT	Date:	Results_____	☐ LA County ☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ LA County ☐ Outside Document	

OR

E	History of Active TB with Treatment	Date:	_____months with_____	☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ Outside Document	

OR

F	History of LTBI Treatment	Date:	_____months with_____	☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ Outside Document	

CONTINUE ON NEXT PAGE

B-NC

CONFIDENTIAL

TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	IDENTIFICATION NO.

G — IMMUNIZATION DOCUMENTATION HISTORY (THESE VACCINATIONS ARE MANDATORY)

	Date Received	Titer	If not immune, give Vaccination x 2, unless Rubella x 1		Date Received	Vaccine		Declined Vaccination
Measles		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**
Mumps		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**
Rubella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 1**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**
Varicella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**

AND

H

Vaccination	Date Received		Declined Vaccine
Tetanus-diphtheria (Td) Every 10 years		☐ Verbal ☐ Document	☐
Arcellular Pertussis (Tdap) X 1		☐ Verbal ☐ Document	☐

AND

I

Vaccination (MANDATORY for WFM who have potential to be exposed to blood or body fluid)	Date Received	Immunity	Declined Vaccine
Hepatitis B (HBsAb)		☐ Reactive ☐ Non reactive ☐ N/A	☐

AND

J

Vaccination (VOLUNTARY)	Date Received	Location Received		Declined Vaccine
Seasonal Influenza (Annually)			☐ Verbal ☐ Document	☐

ATTACH SUPPORTING DOCUMENTATION(S) WITH THIS FORM INCLUDING FORM K-NC IF WFM DECLINED VACCINATION(S)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

GENERAL INSTRUCTION ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	IDENTIFICATION NO.

GENERAL INSTRUCTIONS FOR EACH SECTION

SECTION	
TUBERCULOSIS DOCUMENTATION HISTORY **ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT**	
A	WFM shall receive a baseline TB screening using two-step Tuberculin Skin Test (TST). Step 1: Administer TST test, with reading in seven days. Step 2: After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually. a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work; b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work. If TST is positive, record results and continue to Section C.
B	WFM shall receive a baseline TB screening using a single blood assay for M. tuberculosis (BAMT). If negative result, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually. a. Documentation of negative BAMT within 12 months will be accepted. WFM is cleared to work. If BAMT is positive, record results and continue to Section D.
TST POSITIVE RESULTS **If CHEST X-RAY IS POSITIVE, <u>DO NOT CLEAR</u> FOR HIRE/ASSIGNMENT, AND** **REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE**	
C	If TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.
D	If BAMT is positive during testing in Section D above, send for a CXR. If CXR is negative, WMF is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.
E	If WFM have a documented history of active TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.
F	If WFM have a documented history of latent tuberculosis infection (LTBI) treatment, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.
IMMUNIZATION DOCUMENTATION HISTORY Documentation of immunization or adequate titers will be accepted. If WFM is not immune against communicable diseases as listed in this section, WFM shall be immunized (unless medically contraindicated). WFM who declines the vaccination(s) must sign the mandatory declination form. WFM who declines the vaccination(s) may be restricted from patient care areas of the hospital or facility. If WFM is non-immune or decides at a later date to accept the vaccination, DHS or WFM contract agency will make the vaccination available.	
G	Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted **OR** documentation of two doses (live measles, mumps and varicella) and one dose of live rubella virus vaccine. Measles vaccine shall be administered no earlier than one month (minimum 28 days) after the first dose. Mumps second dose vaccine vary depending on state or local requirements. Varicella doses shall be at least 4 week between doses for WFM. If Equivocal, WFM needs either vaccination or re-draw with positive titer. **DHS-EHS must be notified if WFM does not demonstrate evidence of immunity.**
H	**<u>Td</u>** – After primary vaccination, Td booster is recommended every 10 years. If unvaccinated WFM, primary vaccination consists of 3 doses of Td; 4-6 weeks should separate the first and second doses; the third dose should be administered 6-12 months after the second dose. **<u>Tdap</u>** should replace a one time dose of Td for HCP aged 19 though 64 years who have not received a dose of Tdap previously. An interval as short as 2 years or less from the last dose of Td is recommended for the Tdap dose.
I	All WFM who have occupational exposure to blood or other potentially infectious materials shall have a documented post vaccination antibody to Hepatitis B surface antigen HBsAb (anti-HBs). Hepatitis B vaccine series is available to WFM. Non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAg positive blood.
J	Seasonal influenza is offered annually to WFM when the vaccine becomes available.

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County workforce member's School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

K-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
NON-DHS/NON-COUNTY WORKFORCE MEMBER DECLINATION FORM

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:	
JOB CLASSIFICATION:	DHS FACILITY:	DEPT/DIVISION:	WORK AREA/UNIT:	SHIFT:
NAME OF SCHOOL/EMPLOYER *(If applicable)*:		PHONE NO.:	CONTACT PERSON:	

Please check in the section(s) as apply AND indicate reason for the declination. Submit original to DHS-EHS.

I. ☐ 8 CCR §5199. Appendix C1 - Vaccination Declination Statement (Mandatory)*

Please check as apply: ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Td/Tdap

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection as indicated above. I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring the above infection, a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination from my School/Employer or DHS-Employee Health Services (EHS) at no charge to me.

Reason for declination: _____

_____

☐ Seasonal Influenza

Reason for declination *(check as apply):*

☐ I am allergic to vaccine components.
☐ I believe I can get the flu if I get the shot.
☐ I am concerned about vaccine side effects.
☐ It's against my personal belief.
☐ I don't believe I need it.
☐ I'm concerned about vaccine safety.
☐ I do not like needles.
☐ Other: _____

II. ☐ 8 CCR §5193. Appendix A-Hepatitis B Vaccine Declination (Mandatory)*

☐ Hepatitis B

I understand that due to my occupational exposure to blood or other potentially infectious material (OPIM) I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to me. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from my School/Employer or DHS-EHS at no charge to me.

Reason for declination: _____

_____

III. ☐ Specialty Surveillance Declination (Mandatory)**

Please check as apply: ☐ Asbestos ☐ Hazardous/Anti-Neoplastic Drugs ☐ Other:_____

I understand that due to my occupational exposure as indicated above, I am eligible and have been given the opportunity to enroll in the Medical Surveillance Program. This will enable me to receive specific initial, periodic

PLEASE SIGN ON PAGE 2

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

and exit medical examinations for the hazard identified above, at no charge to me and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this enrollment, I will not be medically monitored for occupational exposure to this hazard. I understand that it is strongly recommended that I complete a medical questionnaire or examination. I also understand that if in the future I continue to have occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, I can do so at any time at no charge to me.

Reason for declination: _____

_____

SIGN BELOW

By signing this, I am declining as indicated on this form.

WORKFORCE MEMBER SIGNATURE		DATE
SCHOOL/EMPLOYER (PRINT NAME)	**SIGNATURE**	**DATE**

MAKE A COPY FOR YOUR RECORDS
SUBMIT ORIGINAL AND ANY SUPPORTING DOCUMENT(S)

*Vaccination(s) is available to all workforce members (WFM), and free of charge for County employees and volunteers. Non-County WFM should obtain the vaccinations from their physician or licensed health care professional. Services provided through DHS will be billed to the non-County WFM School/Employer, as appropriate.

**Non-County WFM who has potential exposure to occupational hazards will be included in the surveillance program, but will not have their assessments done through the County, unless specified in contract/agreement. Medical surveillance/post-exposure regulations are the responsibility of the school/contract agency. If the non-County WFM School/Employer chooses to have DHS-Employee Health Services (EHS) to perform such surveillance/post-exposure services, the non-County WFM School/Employer will be billed accordingly. Emergency services will be provided post-exposure within the allowable time frames, but will be billed to the contractor/agency, as appropriate.

Workforce member must complete this form if declining DHS recommended and mandatory vaccinations or medical surveillance program. The School/Employer must verify completeness and ensure declination form is submitted to DHS-EHS. **The School/Employer must notify DHS-EHS if workforce member does not provide evidence of immunity.**

This form and its attachment(s), if any, such as health records shall be maintained and kept in workforce member EHS health file.

P-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
NON-DHS/NON-COUNTY WORKFORCE MEMBER
8 CCR SECTION 5199 – APPENDIX B
ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

☞ **GENERAL INFORMATION on last page**

Questionnaire for N-95 Respirator

COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED

This Appendix is Mandatory if the Employer chooses to use a Respirator Medical Evaluation Questionnaire other than the Questionnaire in Section 5144 Appendix C (Form O-NC).

To the PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Workforce member must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the WORKFORCE MEMBER: Can you read and understand this questionnaire (check one): ☐ Yes ☐ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please complete this questionnaire in PEN and present to the staff at the examination clinic. **To protect your confidentiality, it should not be given or shown to anyone else.** On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

SECTION 1

The following information must be provided by every workforce member who has been selected to use any type of respirator (please print).

		TODAY'S DATE:	
LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE
HEIGHT FT IN	WEIGHT LBS	JOB CLASSIFICATION	IDENTIFICATION NO.
PHONE NUMBER	Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No	

Check type of respirator you will use (you can check more than one category): ☐ N, R, Or P disposal respirator (filter-mask, non-cartridge type only) ☐ Other type (specify): _____	
Have you worn a respirator? ☐ Yes ☐ No	If "yes", what type:

SECTION 2

Questions 1 through 6 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES", "NOT SURE" or "NO").

YES	NOT SURE	NO	
			1. Have you ever had the following conditions?
☐	☐	☐	a. Allergic reactions that interfere with your breathing?
			If "yes," what did you react to? _____

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

YES	NOT SURE	NO	
☐	☐	☐	b. Claustrophobia (fear of closed-in places)
			2. **Do you currently have any of the following symptoms of pulmonary or lung illness:**
☐	☐	☐	a Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐	☐	b. Have to stop for breath when walking at your own pace on level ground
☐	☐	☐	c. Shortness of breath that interferes with your job
☐	☐	☐	d. Coughing that produces phlegm (thick sputum)
☐	☐	☐	e. Coughing up blood in the last month
☐	☐	☐	f. Wheezing that interferes with your job
☐	☐	☐	g. Chest pain when you breath deeply
☐	☐	☐	h. Any other symptoms that you think may be related to lung problems:_____
			3. **Do you currently have any of the following cardiovascular or heart symptoms?**
☐	☐	☐	a. Frequent pain or tightness in your chest
☐	☐	☐	b. Pain or tightness in your chest during physical activity
☐	☐	☐	c. Pain or tightness in your chest that interferes with your job
☐	☐	☐	d. Any other symptoms that you think may be related to heart problems:_____
			4. **Do you currently take medication for any of the following problems?**
☐	☐	☐	a. Breathing or lung problems
☐	☐	☐	b. Heart trouble
☐	☐	☐	c. Nose, throat or sinuses
☐	☐	☐	d. Are your problems under control with these medications?
			5. **If you've used a respirator, have you ever had any of the following problems while respirator is being used?** ***(If you've never used a respirator, check the following space and go to question 6).***
☐	☐	☐	a. Skin allergies or rashes
☐	☐	☐	b. Anxiety
☐	☐	☐	c. General weakness or fatigue
☐	☐	☐	d. Any other problem that interferes with your use of a respirator
☐	☐	☐	6. **Would you like to talk to the health care professional about your answers in this questionnaire?**

Non-DHS/Non-County Workforce Member Signature	Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 CFR Part 1635

PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL TO COMPLETE NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

FOR COMPLETION BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL
PROVIDE A COPY OF THIS PAGE TO THE WORKFORCE MEMBER

Part 1: Fit Testing Recommendation – Based on Questionnaire

☐ Questionnaire above reviewed.
☐ Medical Approval to Receive Fit Test
1. ☐ Disposable Particulate Respirators (N-95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ The above workforce member has not been cleared to be fit tested for a respirator.
- ☐ Additional medical evaluation is needed. Physician or Licensed Health Care Professional to complete Part 2 below.
- ☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Part 2: Additional Medical Evaluations ☐ NOT APPLICABLE

☐ Medical evaluation completed.
☐ Medical Approval to Receive Fit Test
1. ☐ Disposable Particulate Respirators (N-95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Non-DHS/Non-County Workforce Member Signature		Date	
Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date
Facility Name/Address		Phone No.	

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5199
Medical evaluation: DHS-EHS or non-DHS/non-County workforce member (WFM) School/Employer shall provide a medical evaluation, in accordance with 8 CCR §5144(e) of these orders, to determine the workforce member's (WFM) ability to use the respirator before the WFM is fit tested or required to use the respirator. For WFM who use respirators solely for compliance with subsections (g)(3)(A) and subsections (g)(3)(B), this alternate questionnaire may be used.

8 CCR §5144(e)

1. General. DHS-EHS or non-DHS/non-county WFM School/Employer shall provide a medical evaluation to determine the WFM's ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
   b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part A.
3. Follow-up medical examination.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall ensure that a follow-up medical examination is provided for a WFM who gives a **positive response to any question among questions 1 through 8 in Section 2, Part A** of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
   b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non/DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-EHS form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-Employee Health Services (EHS), the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

Health records will be maintained by DHS-EHS or non-DHS/non-County WFM School/Employer and kept for thirty (30) years after the workforce member's employment/assignment ends, in accordance with State and Federal medical records standards and DHS policies and procedures.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at http://www.dir.ca.gov/title8/5144.html and http://www.dir.ca.gov/Title8/5199.html

T1-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NON-DHS/NON-COUNTY WORKFORCE MEMBER GENERAL CONSENT

LAST NAME:	**FIRST, MIDDLE NAME:**	**BIRTHDATE:**	**IDENTIFICATION NO.:**	
JOB CLASSIFICATION:	**DHS FACILITY:**	**DEPT/DIVISION:**	**WORK AREA/UNIT:**	**SHIFT:**
E-MAIL ADDRESS:	**WORK PHONE:**	**CELL/PAGER NO.:**	**SUPERVISOR NAME:**	
NAME OF SCHOOL/EMPLOYER *(If applicable)*:		**PHONE NO.:**	**CONTACT PERSON:**	

Medical Consent: The undersigned Los Angeles County Department of Health Services workforce member, applicant, and/or responsible relative or person hereby consent to, authorize and request the Department of Health Services (DHS), its physicians, nursing and medical personnel assigned to and authorized by Employee Health Services to administer and perform any and all medical examinations and treatments required for County services. This may include, but not limited to, diagnostic procedures, medical surveillance, post exposure evaluation, tuberculosis screening, drawing blood to determine immunity to infectious diseases, vaccinations and immunizations against disease which may now or during the course of employment/assignment, be deemed advisable or necessary in accordance with federal, state, and local guidelines.

The undersigned further consent to, and authorize, demonstration and/or observations of patient during administration of medical treatment, by physicians, medical students, student nurses and any other proper student or technician whose presence is deemed appropriate by the attending physician.

The undersigned also agrees to fully comply with the rules of DHS and specifically affirm that the Director of DHS will be sole judge of such observance. They further agree that if the workforce member fails to comply with such rules, he/she may be forthwith discharge.

Release of the Information: Upon inquiry, DHS may make available to the public certain basic information about the workforce member, including name, address, age, sex, general description of the reason for treatment, general nature of the injury, and general condition.

The undersigned acknowledges that all workforce members records maintained at any Los Angeles County Department of Health Services facility may be made available for workforce member care, statistical analysis, or research and/or special projects to authorized uses or release as required by law.

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

The undersigned certifies that he/she has read the foregoing, receiving a copy thereof and is the patient, or duly authorized by or on behalf of the workforce member to execute the above and accept its terms.

NON-DHS/NON-COUNTY WORKFORCE MEMBER OR RESPONSIBLE PERSON SIGNATURE		DATE	TIME
WITNESS SIGNATURE		DATE	TIME
WITNESS (PRINT NAME)	RELATIONSHIP TO WORKFORCE MEMBER		
EHS STAFF (PRINT)	EHS SIGNATURE	DATE	TIME

This form and its attachment(s), if any, such as health records shall be filed in workforce member's EHS medical file. All health records of workforce member are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing health information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

DHS is permitted to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This would include, for example, the reporting of a disease or injury; reporting vital events; and conducting public health surveillance, investigations, or interventions.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

T4-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
NON-COUNTY/NON-DHS WORKFORCE MEMBER
NOTICE OF PRIVACY PRACTICES

LAST NAME:	**FIRST, MIDDLE NAME:**		**BIRTHDATE:**	**IDENTIFICATION NO.:**
JOB CLASSIFICATION:	**DHS FACILITY:**	**DEPT/DIVISION:**	**UNIT/AREA:**	**SHIFT:**
E-MAIL ADDRESS:	**WORK PHONE NO.:**	**CELL/PAGER NO.:**	**SUPERVISOR NAME:**	
NAME OF SCHOOL/EMPLOYER *(If applicable)*:		**PHONE NO.:**	**CONTACT PERSON:**	

Effective Date:_____

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices for Los Angeles County Department of Health Services (DHS). DHS Notice of Privacy Practices (the Notice) describes how your protected health information may be used and disclosed and how you can get access to this information. Please read the Notice carefully. The Notice of Privacy Practices is subject to change. Any change in the Notice will be posted on DHS website at www.dhs.lacounty.gov, or you may request a copy from our staff.

I acknowledge receipt of the Notice of Privacy Practices for Los Angeles County DHS.

NON-DHS/NON-COUNTY WORKFORCE MEMBER SIGNATURE:	**DATE:**

INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith effort made to obtain the individual's acknowledgment, and the reason why the acknowledgement was not obtained:

Reasons why the acknowledgement was not obtained:

- ☐ Non-DHS/Non-County Workforce Member refused to sign
- ☐ Other reason or comments:

_____

_____

_____

EHS STAFF NAME (PRINT):	**SIGNATURE:**	**DATE:**